



Public Health  
England

Protecting and improving the nation's health

# **Continuity of care for adult prisoners with a substance misuse need**

## **Report on the London 'deep dive'**

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# 1. Executive summary

## 1.1 Background and method

An integrated pathway of care from prison to community is crucial for reducing reoffending and increasing the recovery rates from drug dependency for those leaving custody. Improving continuity of care is now a strategic priority for PHE, as well as a number of other key organisations. These include NHS England, who are responsible for commissioning prison healthcare and substance misuse services, and the National Probation Service and Community Rehabilitation Companies, both of whom are tasked with coordinating the resettlement of offenders. The National Partnership Agreement for Prison Healthcare cites continuity of care between prison and community support as 1 of the 3 core shared objectives for all partners.

Public Health Outcome Framework (PHOF) Indicator 2.16 is the national indicator which measures the continuity of care for those released from prison with a substance misuse treatment need that are referred to, and subsequently engage with, a community treatment provider. Current data provides evidence that successful transfer in London is low, with only 21% reaching treatment in their local areas following release, even when compared to the relatively low national rate (30%).

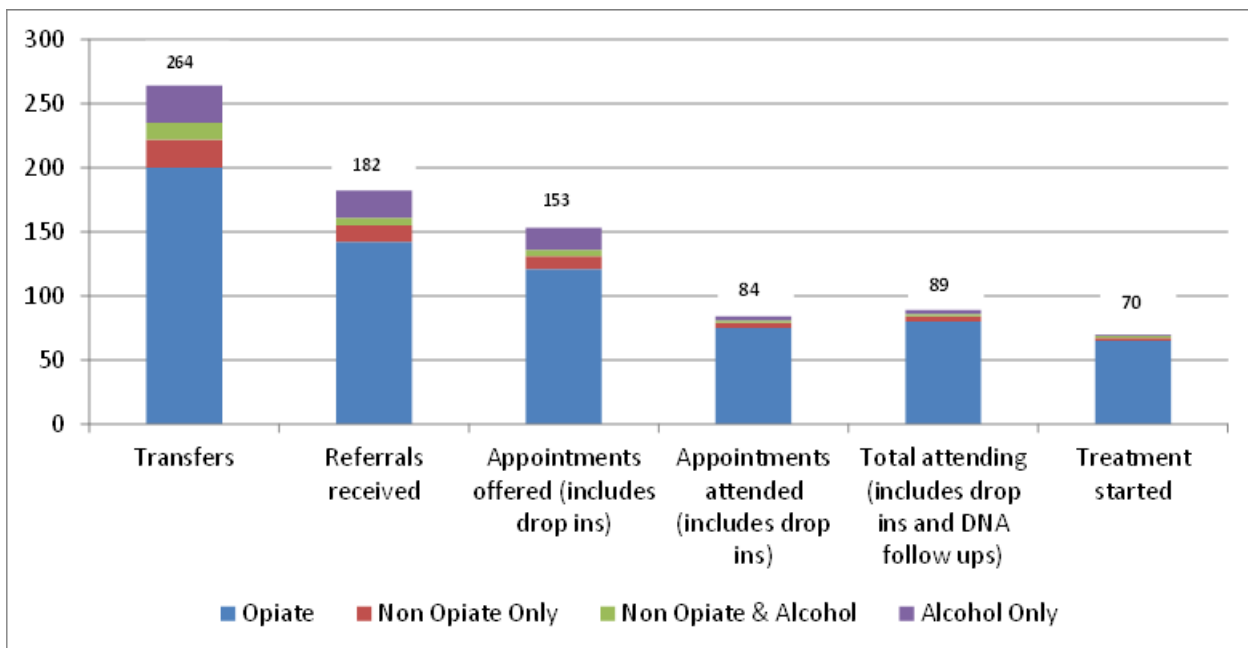
The London PHE Centre established a project to identify the barriers to continuity of care. The project was supported by the Alcohol, Drugs, Tobacco and Justice Division in PHE and the South East PHE Centre National Drug Treatment Monitoring System (NDTMS) team. To support the review, commissioners and providers of substance misuse treatment in 1 of the London prisons and its 5 highest receiving boroughs agreed to participate in an audit of offenders moving between prison and community treatment services in order to track individual cases and analyse the key attrition points. The project also involved meeting with a range of strategic and operational stakeholders in order to review the relevant pathways and provide a qualitative analysis of the processes behind the audit results.

This report summarises the key findings of the London review and makes recommendations based on these findings. The recommendations are intended to support all relevant stakeholders wishing to improve the rates with which prisoners engage with substance misuse treatment following release into their local areas and by doing so improve public health and community safety.

In addition to this report, PHE Alcohol Drugs and Tobacco Division and NDTMS have published a generic toolkit also based on this project, [Continuity of care for adult prisoners with substance misuse treatment need: Audit toolkit and NDTMS recording guidance](#) which should be considered in conjunction with this report.

## 1.2 Key Findings

**Figure 1: Referral pathway between prison and community substance misuse services: key stages of attrition**



Overall the findings from this review suggest that the rate of engagement was 26.5% for the 5 areas involved with 70 out of 264 total transfers subsequently engaging in community treatment.

1. The 'transfer' or 'referral' stage was the biggest point of attrition in the pathway from prison to community substance misuse treatment services. In the second half of 2016 to 2017 a total of 264 transfers were made from the prison to treatment services in the 5 areas participating in the audit. Only 56% of the total transfers from prison were confirmed as referrals received in the community. This increased to 69% when referrals from other sources were included.
2. The second biggest attrition point was the stage between appointments offered in the community and appointments attended, that is those who simply 'did not attend' (DNA) (47%). Appointments were arranged for most clients where a referral was received (79%) but only about half of these clients attended their arranged appointment (53%), including clients who attended the community treatment service without an appointment, referred to as 'drop-ins'.

3. Prison 'in-reach', where community workers visit prisoners before their release to support release and recovery planning, was shown to be a highly effective way of maximising treatment engagement rates following release. Of 182 prisoners who were referred to a community service, 48 (26%) were recorded as having in-reach support from a community worker whilst in prison, and, of these, 80% attended their appointment with substance misuse services on release. Having a prison in-reach service was also shown to improve the sharing of release dates with resettlement agencies. Release dates were not communicated to the community services in 22% of the cases tracked.
4. Referral information from prison substance misuse teams was not comprehensive, with key items missing in significant numbers of cases. Information on any drug testing and treatment licence conditions imposed on release was not routinely recorded. In many cases, mental health and housing need were not recorded. Only 8% of individuals referred were flagged as having a mental health need, and housing needs were flagged in only 25% of the referrals received. In addition, only 31% of clients referred were recorded as being registered with a GP.
5. Only about 1 third of those who failed to attend their community appointment were recorded as having been followed up in any way by the community provider in order to offer a subsequent opportunity to attend and engage with treatment. A handful of those followed up subsequently engaged with community treatment services (22%).
6. Data issues were not found to be a major cause of lower reported engagement. The attributors of the clients transferred were the same in 90% of cases where the client was known to the community treatment services (195 of 217).

### 1.3 Overview of the qualitative findings

The qualitative findings summarised here are based on a series of individual meetings and interviews with prison partners, NHSE and local authority commissioners as well as discussions at various workshops held by PHE London.

It was acknowledged in discussion that valuable work undertaken by a range of partners both in the prison and in the community was not being sufficiently coordinated at the point of release in order to develop the most comprehensive and effective resettlement plans and community referrals. The split between psychosocial and clinical substance misuse provision in prison, with these services being commissioned separately and in this case provided by different organisations, was also cited as acting against seamless care planning and coordination.

Stakeholders reflected that the use of different case management and IT systems within the prison prevented the 2 main substance misuse providers from accessing each

other's case notes and care plans. It was noted that the lack of effective e-mail exchange between the prison and the community was a further barrier to collaborative and effective continuity of care beyond the prison wall. Faxing as a method of referral to the community was seen as unreliable. Most wanted to see a system of reliable secure email being introduced for prison/community communication.

The substance misuse referral forms being used to transfer clients from prison to community services were not always sent within consistent timescales and did not always contain consistent information. There was a consensus that the referral form template could be reviewed by all partners working along the pathway in order to agree content and process.

There was universal recognition of the importance and effectiveness of prison in-reach services in building relationships between prisoners and community workers, and maintaining good working protocols and confidence between the different provider agencies themselves.

Improving coordination and partnership between the London Community Rehabilitation Company (CRC) and community substance misuse treatment systems and their commissioners was considered key to making sure that all possible levers are used to support attendance at community treatment appointments as well as compliance with supervision conditions on release.

Almost all stakeholders discussed in detail the importance of comprehensive substance misuse assessments both before and after release, and how these should be recorded on NDTMS. Data from the audit indicated that the majority of prisoners with a substance misuse need were transferred on NDTMS as 'requiring ongoing structured treatment'. When subsequently assessed in the community, some were identified as needing 'recovery support' rather than care planned structured treatment. Prison staff were clear that given the potential vulnerability of clients leaving prison, established practice was that all prisoners requiring some level of ongoing substance misuse treatment or support should be referred to structured treatment services, irrespective of whether their current need was for recovery support or continuation of structured treatment.

## 1.4 Key Recommendations

The recommendations in this report combine the learning from the London audit and stakeholder review meetings. Further detail is contained in the body of the report. These recommendations should be read in conjunction with those contained in the [PHE toolkit](#). An overview of the key recommendations is presented below.

1. Providers and commissioners should collaborate closely in order to undertake a detailed review of the prison to community treatment pathway in each Local Authority. This should include developing an agreed referral process between prison substance misuse teams and the relevant community treatment providers. Prison and community substance misuse teams will wish to review current referral forms and agree to capture all the key information required by both prison and community teams relating to the individual's needs and ongoing care and supervision. The agreed referral protocol should include how the prison referral is acknowledged as received by the community. This 2-way communication would ideally be done via secure email and the published local treatment Single Point of Contact (SPOC) for treatment referral.
2. Prisons should review how substance misuse treatment services in prisons, both clinical and psychosocial, are informed of prisoner release dates in order to reduce the volume of prisoners released unplanned and therefore without a referral to community treatment. This could be done by working more closely with the prison warrants office. Where prisoners are released unplanned from Court, the wider use of FP10 prescription forms could confirm their ongoing substitute prescribing need and greatly assist the numbers continuing to engage with vital substitute prescribing treatment regimes in the community. The use of prison in-reach services is also shown to improve timely release planning.
3. The CRC and other agencies known to be involved in the prisoner's care and resettlement on release (for example Job Centre Plus, mental health or housing support) should work more closely with both prison and community treatment services to support engagement with community treatment on release. In particular, refreshing the Memorandum of Understanding between each Local Authority and the local CRC will clarify roles and responsibilities and enhance coordinated care and resettlement planning. Sharing information about licence conditions for drug treatment and testing between the prison, CRC and community treatment agencies prior to release should improve levels of compliance with both drug treatment and rehabilitation services on release, enhancing both community safety and the prospect of recovery from drug dependency.



4. Prison in-reach services that make contact with the prisoner prior to release and work to engage the prisoner and develop a mutually agreed and workable release plan are highly effective in supporting engagement with treatment following release. Commissioners and stakeholders ought to consider how they can provide in-reach services to more prisoners, including multi-borough commissioning around prisons in common, and consideration of the use of peer mentoring and volunteer networks and other relevant community resources.
5. Prisons ought to deliver a joint care plan, produced by both the clinical and psychosocial substance misuse teams. This would enhance the quality of information transferred at the point of release, and support engagement with community providers, particularly where there are mental health and housing needs.
6. Prison substance misuse teams will wish to fully assess the clinical and recovery needs of all prisoners on their caseloads prior to release, in order to provide the most accurate and up-to-date information to community treatment. Offering a community treatment appointment on release to all prisoners with ongoing substance misuse needs, whether they are abstinent or not, is good practice. It is endorsed by 2017 [Drug Misuse and Dependence: UK Clinical Guidelines](#) in order to confirm ongoing clinical need. This is also an opportunity to provide naloxone kits to opiate misusers where appropriate on attendance. Where the community treatment provider assesses the released prisoner as needing recovery support rather than structured treatment, the case should be closed on NDTMS as 'treatment complete' and a referral for recovery support made.
7. Community treatment providers and commissioners should maintain regular communication and build relationships with their most relevant prisons to ensure that prison teams are fully informed about the treatment and recovery support on offer in the community, including family support, peer mentoring and mutual aid resources.
8. Community treatment providers and commissioners will wish to work together to ensure that there are rapid prescribing pathways for those who are leaving prison whilst receiving ongoing Opioid Substitution Therapy (OST), including those that have not previously been prescribed in the community.
9. Given the high rate of non-attendance, community treatment agencies will wish to develop a pro-active follow up procedure for released prisoners who fail to attend their first appointment. This could include following up any expected attendance with other agencies known to be involved in their care, for example CRC or housing support. Consideration will need to be given to agreeing the necessary information sharing protocols with relevant partner agencies.

10. Community and prison substance misuse providers who submit their records to NDTMS will wish to follow the correct procedures for transferring clients both in and out of prison, ensuring that cases are closed when clients enter custody. Full NDTMS recording guidance can be found in PHE's [Continuity of care for adult prisoners with substance misuse need: Audit toolkit and NDTMS recording guidance](#). The same guidance document can be used by local areas to conduct their own audit and produce an individual action plan to improve local continuity of care pathways and outcomes.
  
11. Local Authority commissioners of substance misuse treatment services and their provider organisations as well as NHSE, CRC, Mayor's Office of Police and Crime (MOPAC) and Her Majesty's Prison and Probation Service (HMPPS), are encouraged to make full use of local partnership boards and governance structures. These can be used to coordinate relevant services, strategies and outcomes across public health, criminal justice, community safety and social care agendas.

## 2. Introduction

The links between substance misuse and crime, in particular the use of heroin and crack cocaine as drivers of acquisitive crime are well recognised. There is a broad range of both national and international evidence supporting the beneficial impact of substance misuse treatment in reducing re-offending (Hubbard et al 1989; Gossop et al 2005; Hubbard et al 2003; National Treatment Agency 2012).

The government's **2017 Drug Strategy** continues to recognise dependence on Class A drugs as a driver of crime. It details action needed at a national, regional and local level to break the link between drugs and crime, including emphasis on the development of community-based substance-misuse treatment pathways, so offenders can access appropriate treatment.

A recent joint **statistical report** published by the Ministry of Justice and Public Health England evaluated the impact of community-based drug treatment on offending in a cohort of 132,000 individuals engaged in drug and alcohol treatment in England during 2012. Overall, 35% of the cohort had committed an offence in the 2 years prior to entry into treatment, a total of 128,833 offences, with opiate users accounting for a disproportionate level of offending. In the 2 years following the start of treatment 44% of clients did not re-offend and this resulted in the number of recorded offences decreasing by 33%.

For London, the PHE Police and Crime Commissioner Support Pack published in 2017 provides further detailed estimates of the benefits derived from investment in drug treatment in 2016 to 2017. Drawing on PHE's Social Return on Investment of Adult Drug and Alcohol Interventions Toolkit estimates that approximately 722,000 crimes by drug clients and nearly 18,000 crimes by alcohol clients were saved as a result of investment in substance misuse treatment. Total social and economic benefits were estimated at £300m in London. Despite the conservative methodology used, these estimates provide substantial weight to the benefits and importance of engaging drug misusing offenders in substance misuse treatment.

An integrated pathway of care from prison to community is therefore crucial for reducing the reoffending rates and increasing recovery from substance misuse for those leaving custody. The updated 2017 **Drug Misuse and Dependence: UK Clinical Guidelines for substance misuse treatment** dedicates a chapter to the provision of effective substance misuse treatment in prison which is equivalent to that which is available in the community. Considerable emphasis is also given to the 'effective and timely referral routes and channels of communication' between prison and the community to enhance safe continuity of care.

However, the [PHE Drugs Evidence Review \(2017\)](#) identified that continuity of care for substance misusers was 1 of the weaker areas of an otherwise robust UK drug treatment system. Public Health Outcome Framework (PHOF) indicator 2.16 is a national indicator which measures the continuity of care for those released from prison with a substance misuse treatment need that are referred to, and subsequently engage with, a community treatment provider. PHOF 2.16 data covering 2016 to 2017 provides evidence that successful transfer in London is low (21%) even when compared to the relatively low national rate (30%). In London, of 5091 individuals referred from prison to community services, 1075 subsequently engaged in treatment. Similarly, continuity of care for substance misusing offenders between prisons and community treatment is a key service outcome in Service Specification 29 (Public Health Services for Children and Adults in Secure and Detained Settings in England) and is therefore 1 of the performance indicators in the public health functions agreement (Section 7A) to which NHS England is held to account.

Improving continuity of care is now a strategic priority for PHE as well as a number of other organisations including NHS England, who are responsible for commissioning prison healthcare and substance misuse services, and the National Probation Service and Community Rehabilitation Companies (CRC), both of whom are tasked with coordinating the resettlement of offenders.

PHE London established a project to identify the barriers to continuity of care. A key component of the project was to undertake an in-depth analysis of the data recording and operational delivery processes relating to continuity of care of substance misusing offenders leaving custody. Commissioners and providers of substance misuse treatment in 1 of the London prisons and 5 boroughs agreed to participate in an audit of offenders moving between prison and community treatment services. The audit and analysis was led by the Alcohol, Drugs, Tobacco and Justice Division of PHE and the National Drug Treatment Monitoring System (NDTMS) team for the South East. This report summarises the key findings of the review into continuity of care for a cohort of prisoners referred from services in the prison to local treatment services in 5 London boroughs.

## 3. Methods

The review used a mixed methods approach which consisted of the following:

### 1. Task and Finish Group

A Task and Finish Group was established to provide expert oversight and guidance on the direction of the review being taken forward. The role of this group was:

- to support the production of a continuity of care resource pack to maximise effective pathways between prison and community drug services and other organisations supporting recovery
- to identify and draw together key partners who have an interest and responsibility in the effective engagement of prisoners with appropriate community recovery support services, and hence support more collaborative working
- to support more collaborative working between key strategic and operational partners at all levels across a better co-ordinated prison to community pathway

### 2. Meetings with senior stakeholders

In addition to their involvement in the Task and Finish Group, individual meetings were held with partners from London CRC, NHSE, MOPAC and the contracted prison provider to understand their ongoing work and future priorities, and discuss the emerging findings and recommendations for good practice.

### 3. Engagement with the prison

The project team (consisting of a range of PHE staff) visited the prison twice. The first visit involved discussions with staff about operational processes between the clinical and psychosocial provider, barriers and issues experienced in the transfer of clients and links with community teams. Towards the end of the project a meeting was held between the project team and strategic and operational staff within the prison to discuss the final recommendations, review actions taken by the prison substance misuse team and future work planned.

### 4. Workshops held at pan-London substance misuse events covering the 2017 ' Drug Misuse and Dependence: UK Clinical Guidelines for substance misuse treatment' and the [2017 Government Drug Strategy](#)

## 5. Audit of transfers and case file review

A one-off audit was conducted between June and August 2017 of a cohort of prisoners with ongoing substance misuse treatment need who left custody between 1st October 2016 and 31st March 2017. The audit looked at clients transferred from substance misuse treatment services in the prison to community-based substance misuse treatment providers in the top 5 receiving boroughs in London.

Six months' worth of prison treatment data was deemed to provide a representative sample of clients transferred between the prison and community substance misuse treatment services in these boroughs.

The audit comprised of 3 stages:

- stage 1: The treatment service in the prison created a list of clients recorded on NDTMS as transferred to community treatment on release
- stage 2: Community providers checked their local records / files for each client in the list and complete a standard audit template (spreadsheet) for PHE
- stage 3: PHE collated and analysed the audit returns and feedback findings to commissioners and providers (including this report)

PHE developed a set of tools to support the services in the prison and in the boroughs to undertake stage 1 and 2. These included:

- a Data Extraction Protocol to assist the treatment service in the prison with providing lists of clients referred to each borough (as recorded for NDTMS) to share with local treatment services (a copy of the protocol can be requested from the South East NDTMS Team)
- an Audit Spreadsheet for completion by the community services which contained a standard set of questions for each client referral; completion of the spreadsheet was coordinated by the local single point of contact for substance misuses services for criminal justice client
- an Audit Checklist to support community services in pulling together the information required for the Spreadsheet (Appendix A)

The full suite of audit documents is contained in PHE's [Continuity of care for adult prisoners with substance misuse need: audit toolkit and NDTMS recording guidance](#).

The South East NDTMS team supported the psychosocial provider in the prison to provide NDTMS data extracts of clients recorded as transferred to the each of the 5 boroughs participating in the audit. The psychosocial provider copied the data extract for each borough into a blank copy of the Audit Spreadsheet for each borough. The populated spreadsheet was then shared with the Single Point of Contact for the

borough via secure Criminal Justice Secure e-mail (CJSM). The prison treatment data items populated in the Audit Spreadsheets are listed in Appendix B.

Community services were asked to complete the remaining questions in the Audit Spreadsheet. These were focused on the referral process and engagement of the client post-release. Where a client had more than 1 referral during the 6-month period covered by the Audit (due to more than 1 prison stay), providers were asked to complete the questions for each separate referral as both 'transfers' could have resulted in a post-release engagement, and therefore both are counted in the denominators of the PHOF and 7a measures.

Once the Audit was completed for all transfers the spreadsheet was sent to the PHE NDTMS secure drop box for collection and analysis, excluding the personal data (names, date of birth, prison national offender management information system (p-NOMIS number)). The records in the Audit were assigned to substance groupings for the analysis, based on the clients' problematic substance/s recorded for NDTMS. The substance groupings used are consistent with the groupings used for wider NDTMS reporting; opiate clients, non-opiate clients, non-opiate and alcohol clients and alcohol only clients. In addition, where relevant the time spent in custody at the prison has also been considered in the analysis to explore whether length of stay impacts on continuity of care.

## 4. Findings

### 4.1 Qualitative findings

This section of the report outlines the qualitative findings from the engagement with stakeholders across the various elements of the pathway. It draws on discussions with partners working inside the prison, commissioners, providers of community substance misuse services and discussions with colleagues in the criminal justice system.

The 4 key themes arising were:

#### 4.1.1 Transfer process

Partners reported working within 'silos' both inside and outside of the prison. In prison, despite the wide range of assessments completed, staff reported not being sighted on the outcome of the different assessments. This contributed to low levels of need (for example mental health, housing, criminogenic need and licence conditions) being recorded in release documentation and subsequently shared with community partners. Some raised the risk that insufficient information on file could lead to an 'alert' form not being issued or a referral not being made prior to the prisoner being released. Partners recognised the disconnect between prison-based clinical and psychosocial teams working for different providers and sometimes different commissioners. This led to problems sharing information such as care plans and court dates, where they cited limited opportunity to contact the prisoner in advance of their potential release, or to make a timely community referral. Discussions revealed that there were many issues underpinning the silo working, such as teams working in different locations within the prison, to different specifications and from different IT and case management systems. All of this limited the ability to share care plans and other information.

'Silo working' also existed across the prison wall, in the interaction between prison and community teams. There was little evidence of any direct 2-way communication between the referring team in prison and the community service. Community teams receiving referrals frequently relied on receiving faxes and there was little follow-up built into the system to acknowledge whether an individual had attended the community appointment. A functional email box existed for confirmation of referrals but some were not confident that this would always be monitored or whether this was routinely used.



There were many reports of significant limitations imposed by the IT systems in place, including issues around exchanging emails with attachments in a secure manner. Maintaining direct communication between the prison and community substance misuse teams involved was challenging not least because of the number of different boroughs and teams, but also because of recommissioning, staff turnover and variations in local arrangements.

#### 4.1.2 Reflecting clinical need and NDTMS

Data from the audit indicated that the majority of prisoners with a substance misuse need were transferred on NDTMS as requiring ongoing structured treatment. When subsequently assessed in the community some were identified as needing recovery support rather than care-planned structured treatment. Prison staff were clear that given the potential vulnerability of clients leaving prison, established practice was that all prisoners requiring some level of ongoing substance misuse treatment or support were referred to structured treatment services, irrespective of whether their current need was for recovery support or continuation of structured treatment. This is consistent with the advice given in the 2017 [Drug Misuse and Dependence: UK Clinical Guidelines](#).

As part of this detailed discussion it became clear that given the day-to-day demands on teams, they had limited opportunity to engage with the wider role of NHSE and PHE, and the context in which this data is being reported and used. It is important that staff get regular access to PHE NDTMS training. Recommendations on the accurate assessment of need and how this should be recorded on NDTMS are made in subsequent sections of this report.

#### 4.1.3 Prison in-reach

Findings from the audit strongly endorsed the effectiveness of prison in-reach services in supporting engagement with treatment on release. It was also evident from our discussions with prison teams that providing a community worker who visited the prison was hugely valued. This enabled the in-reach worker to have direct access to information such as release dates, to plan for more co-ordinated care and to better promote the community offer to prison team members and prisoners alike.

Prison in-reach arrangements can be varied and innovative. Some prisons have restricted-use telephones within the cells, others may have access to IT which could contain details of the community service and what to expect. The prison offered a group room to community workers wishing to meet separately with several prisoners in 1 visit, and invited them to regular meetings to discuss specific prisoners. These were good opportunities to strengthen release preparation and planning but were not always known about or taken up by community teams. Given the number of community services that the prison team refers to, it was clearly a challenge for prison staff to be

familiar with details of each community offer and how structured treatment and recovery support services differ as well as the range of community recovery resources available to the prisoner on release, all of which are important if they are to motivate prisoners to attend these services. Stakeholders were keen to hold a sub-regional community network event with their peers in the community to develop relationships, increase their knowledge of what's on offer and generally improve the effectiveness of the transfer and pathways out to communities. This could be taken forward locally.

Opportunities around in-reach were also discussed at a number of pan-London substance misuse events as well as the potential for boroughs to co-commission in-reach resources into prisons of shared interest, either based in prison 'reaching out' or outside prison 'reaching in'. There seems to be an appetite amongst a number of senior partners in the criminal justice service and a number of community substance misuse commissioners to support a sub-regional approach to in-reach support. PHE will continue to discuss this further with partners.

#### 4.1.4 Co-ordinating community settlement

Co-ordinating resettlement back into the community is the responsibility of a number of partners, all of whom will be required to engage with the same individual. This review identified a significant disconnect reported between these agencies. Community substance misuse commissioners felt unclear as to how the licence conditions to attend treatment post-release were operating in their area, and also whether breaches of licence conditions were still prosecuted. Treatment services were not sufficiently sighted on the wider range of needs of an individual leaving prison which relates to the lack of a synthesis of information and an integrated referral process prior to release.

Of those who attended the external events, few community commissioners reported having an established agreement of how they work with the CRC. Many said at that time that they no longer had an agreed up-to-date Memorandum of Understanding with the agency. The CRC have spent much of the year prior to this review focused on internal development, and partners expressed some lack of clarity about the organisational role and joint working opportunities. However the CRC have now developed a new Custody team which will be structured on a locality basis. The contact list for these teams accompanies this report as a separate document. The function of these teams is to assist and strengthen the pathway from prison to community for offenders. Refreshing the Memorandum of Understanding between each local authority and the London CRC would also help strengthen the links between organisations and also clarify the role of the CRC.

At some of the engagement events that were held (for example PHE's Drug Strategy event workshop) community partners were keen for opportunities for greater information sharing with CRC and to work more closely together. It is clear that closer working of partners within the community will help maximise the joint levers that Job Centre Plus/Community Rehabilitation Company/ National Probation Service share so that all leverage is used to support attendance and engagement with treatment and resettlement agencies on release.

Discussions with stakeholders from NHS England (NHSE) and Her Majesty's Prison and Probation Service highlighted that the transformation of the prison estate in London is underway and this will mean that some prisons will change roles and become reception prisons, managing those on remand or serving a sentence of less than 56 days. Community treatment services reflected that they would benefit from understanding the specific population of the prisons referring to their local borough at volume. Prisoners' substance misuse needs will vary and the system of referral and community pick-up needs to be set up with this in mind.

The second biggest point of attrition in the pathway was the failure of released prisoners to attend the appointment offered with the community treatment agency. Colleagues suggested using a range of approaches on a number of occasions, such as phone/text/email/letter. Some also suggested having close links with the Integrated Offender Management team who may be engaged with the prisoner on release and may be able to encourage engagement with drug treatment if the first appointment has been missed.

The difficulties of following up clients that were of no fixed abode were well recognised, and different boroughs had varying local practices. It was acknowledged that last known address, GP registration and probation are all key points of contact, as well as checking the last treatment service they attended to help locate them. All of this is information that could be considered for inclusion in the prison's substance misuse referral form to the community with the client's consent.

## 4.2 Data Audit Findings

This section of the report summarises the key findings of the case file audits undertaken by the 5 local areas for clients transferred from the prison between October 2016 and March 2017.

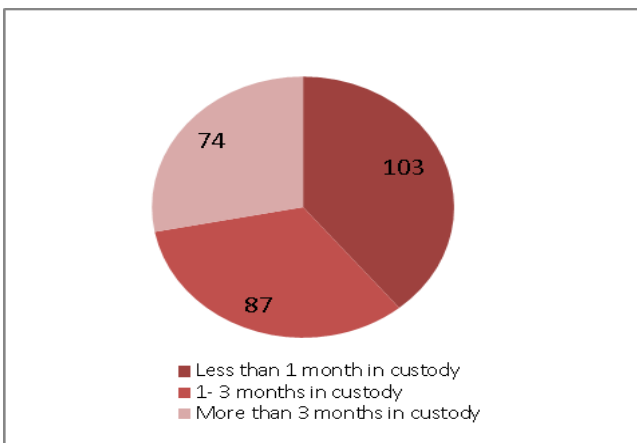
### 4.2.1 Referrals

#### Transfers from prison treatment to community treatment

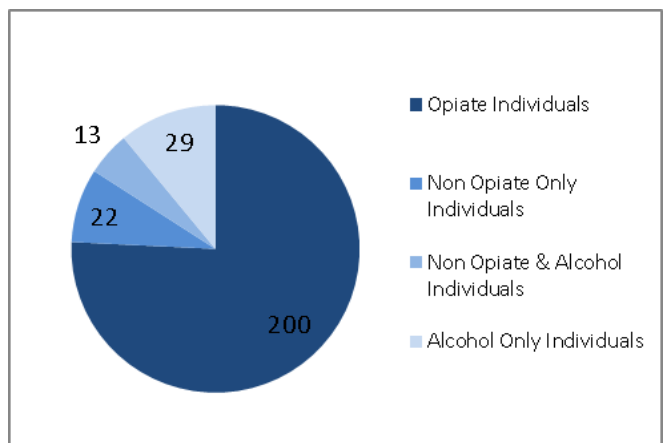
Based on the data extracted from NDTMS by the psychosocial provider in the prison, a total of 264 transfers to community treatment services in the 5 London boroughs taking part in this review (referred to as the 'areas') were recorded for the 6 month period October 2016 to March 2017. The cohort consisted of 200 opiate clients (76%), 22 non-opiate clients (8%), 29 alcohol only clients (11%) and 13 non-opiate and alcohol clients (5%).

103 individuals had been in custody for less than 1 month (39%), 87 for 1 to 3 months (33%) and 74 had been in custody for more than 3 months (28%). Figure 2 provides a breakdown of individuals transferred by substance group and time in custody.

**Figure 2:**  
**Individuals transferred by time in custody**



**Individuals transferred by substance group**



#### Matching of attributors of clients transferred

The attributors of the clients transferred (initials, gender and date of birth) were the same in 90% of cases where the client was known to the community treatment services (195 of 217). Of the 180 opiate clients known to the community treatment services the attributors matched for 163 (91%). There were no substantial differences between substance misuse groups.

This suggests that the low engagement rates reported in the PHOF are not due to attributor errors leading to clients not being matched within NDTMS. However, prison and community substance misuse providers should monitor the accuracy of data recording on NDTMS to further reduce any data anomalies.

## Referrals and 'alert' forms received

Referrals were confirmed as received by the local community treatment services for 149 of the 264 total transfers (56%). Most of these (139) were received from the psychosocial service in the prison and the other 10 were from the clinical service. The majority of referrals (79% or 118) were for opiate clients. The method of referral was recorded in 138 cases; 127 (92%) of them were faxed to the community providers from the prison.

Table 1 below shows the number of transfers made and the number of referrals received by substance misuse group. Whilst opiate clients formed the bulk of the referrals received by the community service from the prison, only 59% (118 of 200) of all opiate client transfers resulted in a referral being confirmed as received in the community.

**Table 1: Total transfers made and referrals confirmed as received by substance group**

	Transfer made	Referral received	Percentage received
<b>Opiate transfers</b>	200	118	59%
<b>Alcohol only transfers</b>	29	17	59%
<b>Non-opiate and alcohol transfers</b>	13	3	23%
<b>Non-opiate</b>	22	11	50%
<b>Total</b>	264	149	56%

In general, referrals from the psychosocial team in the prison were via an 'alert form' which was faxed to the community treatment single point of contact. Alert forms are usually sent to the community to inform them that a local resident has engaged with the psychosocial treatment service whilst in custody. Where possible, alert forms are also sent prior to release to inform the community that the client is returning to the borough with ongoing structured treatment and/or recovery support need. In most cases the alert forms act as the referral. Alert forms were received for 149 of the 264 transfers (56%), with 7 of these sent from court rather than from the prison. It is not clear what form the referral took for the additional 114 transfers for whom an alert or other referral form was not identified.

There was no significant difference in the proportion of alert forms received by time in custody. Three of the referrals / alert forms were not appropriate to the local service because the client was referred to the wrong borough or had moved out of the area. These clients are excluded from the data from this point forward.

From this point onwards in the report a 'referral received' includes those cases where the community received a referral from any source. Based on this methodology the community services in the 5 local areas registered referrals for 182 of the 264 transfers from the prison. Table 2 below shows a breakdown of the total referrals received for each substance group and by 'time in custody' groups.

**Table 2: Transfers and referrals received by substance and time in custody**

		Total transfers from prison	Total referrals received from all sources	%
<b>Substance Group</b>	<b>Opiate client</b>	200	142	71%
	<b>Non-opiate only</b>	22	13	59%
	<b>Non-opiate &amp; alcohol</b>	13	6	46%
	<b>Alcohol only</b>	29	21	72%
<b>Time in custody</b>	<b>&lt;=1month</b>	103	67	65%
	<b>1-3 months</b>	87	68	78%
	<b>&gt;3 months</b>	74	47	64%
<b>TOTAL</b>		<b>264</b>	<b>182</b>	<b>69%</b>

Overall, referrals were received for 69% of the transfers.

## Recommendations

The referral data provides evidence that despite the prison substance misuse team having stated that they made a faxed referral to the community provider nominated by each borough, these were not being formally received by the community provider in a significant number of cases. The referral stage is the biggest cause of attrition in the pathway.

Continuity of care for substance misusers from prison to community would be significantly enhanced by the development of an agreed referral protocol between prison substance misuse teams and community treatment providers. Setting up a local meeting of stakeholders may be the best way to achieve this. Developing a formal referral protocol is an opportunity for the prison to make the most effective referral, transferring as much relevant information as possible, including:

- current substance misuse treatment and recovery needs and previous contact with treatment agencies
- details of any licence condition to attend treatment and the relevant CRC contact
- any housing need and referral details, including last known address
- any mental health need and referral details
- any other community referrals made and relevant contact details
- GP details or plans to register with a GP

The referral protocol could include an expectation that the referral is formally acknowledged by the community provider on receipt, and an appointment for an assessment provided. Where a referral is not rapidly acknowledged, the prison substance misuse team may wish to adopt a robust follow-up system with the community team. Referrals made by secure email should be considered the most robust method, supported by documented 2-way communication between the prison and community teams.

PHE London’s Drug and Alcohol community treatment Single Point of Contact (SPOC) list can be used to make an initial telephone referral to any local authority area in London. For referrals to areas outside of London, the national SPOC list can be used.

### 4.2.2 Communication of release dates

According to local treatment services in the 5 areas, release dates were communicated for 78% of the referrals received (142 of 182). The data suggests that the longer an individual remained in prison the more likely the release date was to be communicated (68% for those in the prisons for less than 1 month compared to 93% for those in the prison for more than 3 months). There was no significant variation between substance groups.

**Table 3: Referrals with release date communicated**

		Total where community treatment received a referral	Total where the release date was communicated	%
<b>Substance Group</b>	<b>Opiate client</b>	142	108	76%
	<b>Non-opiate only</b>	13	10	77%
	<b>Non-opiate &amp; alcohol</b>	6	6	100%
	<b>Alcohol only</b>	21	18	86%
<b>Time in custody</b>	<b>&lt;=1 month</b>	66	45	68%
	<b>1-3 months</b>	68	54	79%
	<b>&gt;3 months</b>	46	43	93%
<b>TOTAL</b>		<b>182</b>	<b>142</b>	<b>78%</b>

Generally, it is to be expected that the longer a client is in custody the more likely the service in the prison are to know the timing of the client’s release, to be able to plan for it and to be able to communicate it to the community. It is assumed that a significant number of those for whom the release dates were not communicated to the community providers will have been released unexpectedly from court.



## Recommendations

It was recognised that it can be a challenge to share release dates with prison substance misuse teams promptly. This could be addressed in part by reviewing the involvement of the prison warrants office to see if more dates could be shared. Prisoners (especially those on remand) going out to Court from prison should be given an FP10 form or an equivalent document outlining their current treatment regime to facilitate rapid prescribing in the community. An FP10 is a prescription form purchased by NHS organisations and distributed free of charge to medical and non-medical prescribers in other organisations as required.

Commissioners could promote local substance misuse pathways with other stakeholders working in the Court system for example CRC colleagues.

### 4.2.3 Involvement of the CRC and recording and sharing of Licence conditions

During the audit it was noted that the community teams did not consistently record details of whether the prisoners being released had a licence condition to attend treatment. Also, whether the CRC were involved in the supervision of drug misusing offenders on release was not routinely recorded. In most cases the audits either left this question blank or recorded 'don't know'.

## Recommendations

There was a missed opportunity to record and share information on whether the prisoner had a licence condition to attend community drug treatment services on release. Improving this could allow both reoffending and treatment services to increase compliance and engagement with treatment and testing licence conditions, and improve rates of compliance with both services.

Refreshing the Memorandum of Understanding between each Local Authority and the London CRC will offer commissioners and providers the opportunity to clarify the respective roles and responsibilities of CRCs and treatment providers in managing drug using offenders on release from prison. This could include the agreement of information sharing about levels of compliance with licence conditions which include stipulations for drug treatment and testing. Such an agreement might usefully include links to the new community based Custody CRC teams who are tasked with assisting engagement with rehabilitative services after release. The contact list for the London Custody CRC teams is available as a separate document.

#### 4.2.4 Prison in-reach activity

There was little evidence of face-to-face contact between the community treatment services and the prisoners transferred to them during the time the prisoners were in custody. Of the 182 referred to the community, only 48 individuals (26%) were recorded as having contact made with them whilst in prison. Almost 80% of these positive contacts were undertaken by the dedicated prison in-reach team operated by 1 of the areas.

Appointments with community treatment providers were made for 45 of the 48 referrals who were contacted whilst in custody (94%). Eighty percent (36) of these attended the appointment on release, a significantly higher proportion than for clients who had no contact with community services prior to release (29% or 39 out of 134 referrals). The attendance rates are discussed in more detail in the appointments section of this report.

Only 12 clients across the 5 areas were met at the gate on release, 1 by a community treatment service and 11 by the dedicated in-reach team. Most of those who were met were opiate clients (10) and all whom engaged in treatment on release.

#### Recommendations

Prison in-reach services that make contact with the prisoner prior to release and work to engage the prisoner and develop the release plan are highly effective in supporting engagement with treatment following release. Commissioners and stakeholders might wish to consider how they can provide in-reach services to prisoners, including multi-borough commissioning around prisons in common. They should also consider the use of peer mentoring and volunteer networks and other relevant community resources designed to help drug misusers to engage successfully with treatment and support programmes.

#### 4.2.5 Client needs on release

Most of the 182 referrals received by the community were for clients who were recorded as having a need for structured treatment (82% or 150) and/or for recovery support (69%, 126). Although not recorded in the table it is worth noting that over half were recorded as needing both (59%, 108). Information on treatment need was not recorded for 14 referrals.

**Table 4: Treatment needs of all referrals received**

		Total referrals received	Structured treatment	Recovery support	OST – maintenance or reduction	Housing need flagged	Mental Health need flagged
<b>Substance Group</b>	<b>Opiate client</b>	142	127 (89%)	96 (68%)	91 (65%)	37 (26%)	10 (7%)
	<b>Non-opiate only</b>	13	7 (54%)	8 (62%)		2 (15%)	1 (8%)
	<b>Non-opiate &amp; alcohol</b>	6	4 (33%)	6 (100%)		1 (17%)	1 (17%)
	<b>Alcohol only</b>	21	12 (57%)	16 (76%)		4 (19%)	3 (14%)
<b>Time in custody</b>	<b>&lt;=1 month</b>	66	60 (91%)	43 (65%)	39 (59%)	18 (27%)	4 (6%)
	<b>1-3 months</b>	68	57 (84%)	46 (68%)	35 (51%)	14 (21%)	5 (7%)
	<b>&gt;3 months</b>	47	33 (72%)	37 (79%)	17 (36%)	12 (26%)	6 (13%)
<b>TOTAL</b>		<b>182</b>	<b>150 (83%)</b>	<b>126 (69%)</b>	<b>91 (50%)</b>	<b>44 (24%)</b>	<b>15 (8%)</b>

Approximately 2 thirds of the opiate referrals received were for prisoners who were known to be receiving Opiate Substitution Therapy (OST) at the point of referral (65%, 91 of 141) and most of these, 87% (79 of 91), were being maintained at release. Four opiate clients referred to community treatment services were abstinent at release. The community treatment services did not record or did not know the prescribing status of 47 other opiate referrals.

The data suggests that prisoners who had been in custody for more than 3 months were slightly less likely to require structured treatment (72%) and more likely to need recovery support (79%) compared to those who had been in for less than 3 months (87% and 66% respectively).

## Mental health needs

Only 15 (8%) of the prisoners referred to community treatment were reported in the referral document as having a mental health (MH) need. This is not consistent with the common understanding of a larger overlap between mental health needs and substance misuse. Research shows that mental health problems are experienced by the majority of drug (70%) and alcohol (86%) users in contact with treatment services ([Better Care for people with co-occurring Mental Health and Alcohol and Drug Use Conditions PHE 2017](#)). Whilst a large proportion were recorded in the audit as not having a mental health need noted in the referral (73% or 133 of 181), for nearly 20 per cent (33) of the referrals the relevant audit question was not completed in the audit returns. It is, therefore, not possible to ascertain whether mental health need was recorded in more cases nor the true level of need amongst those referred.

## Housing need

Nearly half of the referrals received were reported as not having a housing need in the referral (89), but again the housing need question was not completed for a number of referrals (49) and so this is an incomplete picture. In a quarter of referrals received, a need for housing was reported (44).

## GP registration

Less than a third, 31% (57), of the clients referred were recorded as being registered with a GP, mostly opiate clients (48). Only 3% (5) were recorded as not registered with a GP. For many referrals the community providers either recorded in the audit that they did not know if the client was registered with a GP (113) or left the item blank (7), which included 46 opiate clients released on OST and recorded as being known to community services.

## Recommendations

Despite the evident hard work by different prison providers including substance misuse and resettlement teams, information was not being effectively coordinated to support transfer back to the community. Delivering a coordinated care plan, at least between clinical and psychosocial prison substance misuse teams, can significantly enhance the quality of information transferred at the point of release. This can support engagement with community providers, particularly where there are mental health and housing needs.

Once the referral has been successfully made and acknowledged, all stakeholders will wish to consider how to make the best possible offer to prisoners in order to improve the take-up rate of post-release appointments and subsequent engagement with treatment:

- commissioners and community providers could make information about their local treatment and recovery systems and resources available to their main referring prisons and use in-reach services where possible to adequately prepare prisoners for release
- community treatment providers and commissioners will wish to ensure that there are rapid prescribing pathways for those who are leaving prison whilst receiving ongoing Opioid Substitution Therapy (OST), including those that have not previously been prescribed in the community
- prison substance misuse teams should be able to describe the community services and recovery support available to prisoners on release, including any mutual aid networks
- release plans should include the involvement of family members, carers or peer mentors who can support engagement with treatment and recovery resources on release
- registering prisoners with a GP in their local community should be seen as a priority and the address of the CRC officer can be used if needed

#### 4.2.6 Community appointments offered and attended

Of the 182 referrals received by the community services from all of the sources described, 144 (79%) were offered an appointment. A further 6 clients (3%) appear to have dropped into their local service (or attended an 'emergency slot') and 3 clients for whom no referral was recorded as received (from any source) attended an appointment in the community within a day of release. This combines to a total of 153 cases being offered an appointment or dropping in to community treatment services following release from the prison.

**Table 5: Total referrals received and appointments offered (including drop-ins)**

	Referrals received plus total drop-ins	Appointments offered plus total drop-ins	Appointments attended
Opiate client	151	121	69 (57%)
Non-opiate only	13	10	4 (31%)
Non-opiate & alcohol	6	5	2 (30%)
Alcohol only	21	17	3 (14%)
<b>TOTAL</b>	<b>191</b>	<b>153 (80%)</b>	<b>78 (53%)</b>

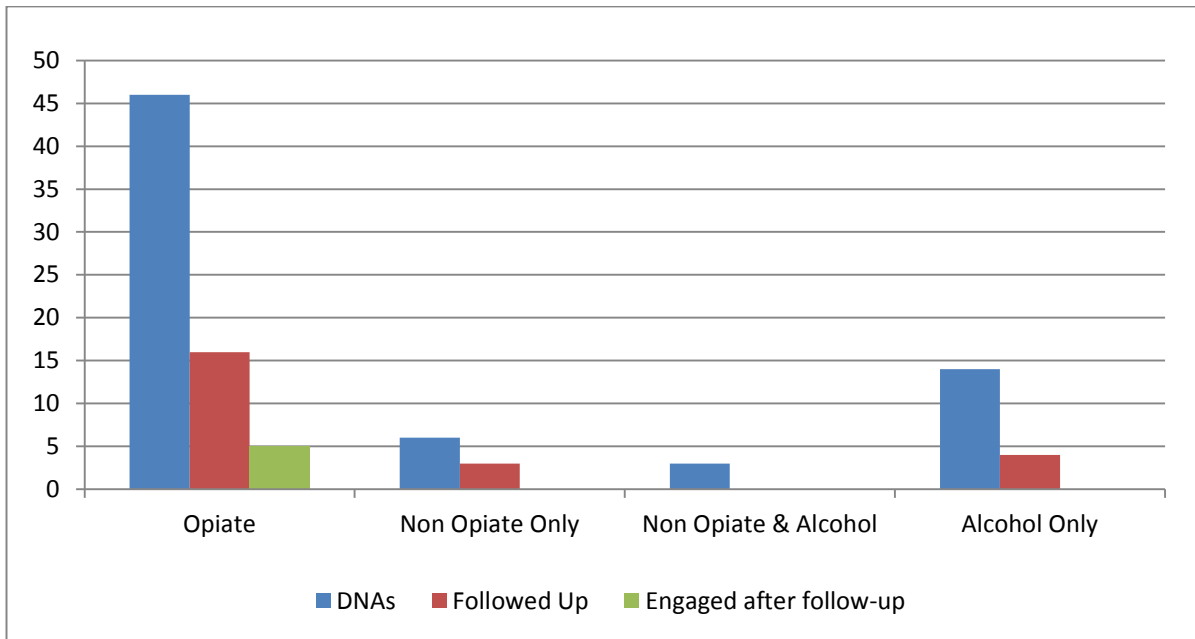
Table 5 provides a breakdown of the proportion of appointments offered by substance group. It shows that a similar proportion of those referred across the 4 substance groups were offered an appointment.

**Failure to attend community appointments**

Almost half of the 147 appointments made were not attended (69 or 47%). Higher proportions of each of the non-opiate, non-opiate and alcohol and alcohol only cohorts did not attend their appointment compared to the opiate clients. Two thirds of the 'did not attends' (DNAs) (66% or 46 of 69) were not followed up by the community provider (Figure 3).

Of the 23 (32%) DNAs who were followed up, 16 (70%), were sent a single letter, phone call or text, and the rest received 2 or more contact attempts. The cases followed up resulted in 5 more people subsequently engaging in drug treatment.

**Figure 3: 'Did Not Attend' appointments and numbers followed up by substance group**



The data suggests that regular follow-up of DNAs is low but if this were increased more people are likely to engage.

## Recommendations

Given the high rate of non-attendance, community treatment agencies will wish to develop a pro-active follow up procedure for released prisoners who fail to attend their first appointment. This could include following up attendance with other agencies known to be involved in their care, for example CRC or housing officers. Consideration will need to be given to agreeing the necessary information sharing protocols with relevant partner agencies.

## 5. Recommendations for getting NDTMS recording right

NDTMS data is the source for the PHOF 2.16 indicator on continuity of care for clients leaving treatment in custody and returning to the community with an ongoing structured treatment need. The indicator shows the proportion of transfers that resulted in client engagement post-release. The (2016-17) PHOF 2.16 indicator for the 5 areas was 22.9%. This figure includes transfers from all prisons to the borough and is therefore not specific to those leaving the prison involved in this review, although it remains the largest individual source of transfers to the 5 areas and accounts for approximately 40% of the total number of prisoners transferred for substance misuse treatment to these areas.

PHE provide additional restricted data to local authority commissioners to support understanding of local PHOF performance and to NHS England commissioners as part of the routine quarterly performance reporting on treatment delivered in prisons.

Findings from both the quantitative research and the data audit suggested that Community providers would benefit from reviewing and ensuring that staff follow the correct NDTMS procedures for transferring clients both in and out of prison, ensuring that cases are closed when clients enter custody. Full NDTMS recording guidance can be found in PHE's [Continuity of care for adult prisoners with substance misuse need: Audit toolkit and NDTMS recording guidance](#).

On reception at the community service the client should receive a comprehensive assessment to ensure that the treatment they receive in the community meets their needs. This is consistent with the 2017 [Drug Misuse and Dependence: UK Clinical Guidelines](#) which recommend that community substance misuse treatment providers should assess the needs of prisoners immediately after release from prison to confirm a clinical or recovery support need.

To enable NDTMS to identify the clients that are expected to engage with structured treatment on release (and therefore who should appear in the community structured treatment data), it is important that prison treatment providers discharge clients correctly depending on their ongoing treatment need. Clients who are being released from prison and require ongoing structured treatment should be discharged as 'transferred not in custody' with a referral on release status of 'referred to structured treatment' or 'referred to structured treatment and recovery support'.



It is recommended that providers in the boroughs check that the dates for those who started treatment have been recorded correctly in NDTMS, particularly for any clients who were already in treatment with the provider prior to their custodial stay. New intervention start dates should be recorded for all treatment starts following release, even if clients have only been in custody for a short period of time and are 'still in treatment' with the community provider whilst in custody.

## 6. Conclusion

Staff working along the prison to community pathway were dedicated, skilled and committed to making a difference to the lives of the prisoners in their care. However, the majority of drug misusing prisoners referred to community services for substance misuse treatment on release are not reaching those treatment systems, and this means that a vital opportunity to reduce future reoffending rates by capitalising on the recovery and resettlement work done in custody is being missed. Those misusing opiates are also at higher risk of drug-related death on release from prison, and successful engagement with treatment could protect them from this risk.

This report has demonstrated that prison in-reach is clearly one of the most effective approaches to ensuring the effective engagement of prisoners back in the community and was highly valued by all stakeholders. How prison in-reach activity can be extended when funding is stretched is a challenge that could be addressed in part by co-commissioning around prisons and by using the raft of peer, family and mutual aid support in greater measure.

Referral information that is shared across the prison wall at the point of release could be much more streamlined and comprehensive, better reflecting and integrating the range of activity undertaken within prison to ensure that community agencies have the best possible picture of the needs of the individual who is being referred. This is especially important where there are mental health and housing needs which can undermine the likelihood of engagement with community substance misuse treatment.

Local prison and community partners would benefit greatly from working closely together to agree a robust referral protocol which is monitored for effectiveness and regularly reviewed. Better sharing of prison release dates between agencies would also allow for more effective planning and engagement back into the local community where prisoners re-establish their lives.

There are renewed opportunities to ensure that the resettlement and supervisory roles of the National Probation Service and CRCs are used to support compliance with community treatment on release, especially where conditions for drug testing and treatment are written into post release licences. Agreeing roles and responsibilities on a borough by borough basis and sharing local information and governance structures can assist this and shore up community safety.

Data recording and transfers should be made according to the NDTMS business definitions and UK Clinical Guidelines that recognise the need for further assessment of the individual when returning back into the community, in order to reduce the risk of

relapse and overdose. Substance misuse teams within the prison and in the community could be given greater opportunities to explore and understand the rationale that underpins the established guidance and protocols. Face-to-face meetings in order to review and agree the local adoption of continuity of care processes underpinned by support and guidance from their commissioners would also be invaluable.

There is a clear role for the strategic partners with a stake in improving the levels of engagement of prisoners in drug treatment on release, including NHSE, CRC, MOPAC and HMPPS as well as community treatment and recovery provider organisations and their commissioners, to support the recommendations in this report through their own governance structures and influence.

It is encouraging that there is now a real appetite to explore these opportunities afresh, as well as the potential for cross-boundary models of commissioning for prison in-reach services. This report and the accompanying **PHE national guidance** can now form the basis of local audits and reviews which will strengthen continuity of care from London's prisons to local community treatment systems. The potential benefit of establishing a seamless, integrated and rapid transfer of individuals with a substance misuse need from prison to the community is clear, not least for the health and well-being of the individuals and their families, but also to improve the safety of our London communities.

## Acknowledgements

We would like to thank the prison teams and community substance misuse treatment providers for their time and contribution to this work which has been invaluable.

## Appendices

### Appendix A: Audit questions (Checklist)

1	Is the client known to the service?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
2	Do the client attributors (initials, DOB) match the prison data?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
3	Did the service receive a referral from the prison (prior to or on release)?	Yes – from Healthcare <input type="checkbox"/>	<b>Yes – from Psychosocial team</b> <input type="checkbox"/>	Yes – from both <input type="checkbox"/>	No <input type="checkbox"/>
4	How was the referral received? <i>(Tick the 1 that is most applicable)</i>	Phone <input type="checkbox"/>	<b>Email</b> <input type="checkbox"/>	Fax <input type="checkbox"/>	In-reach <input type="checkbox"/>
5	Did the service receive an 'alert' from the prison or court teams about the client's release? <i>(Tick 1)</i>	Yes – from prison <input type="checkbox"/>	<b>Yes – from court</b> <input type="checkbox"/>	No <input type="checkbox"/>	
6	Did the service have any contact with the client whilst in prison?	Yes – in person <input type="checkbox"/>	<b>Yes – via phone</b> <input type="checkbox"/>	No <input type="checkbox"/>	
7	Did the prison inform the service of the release date?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
8	Was the referral appropriate? <i>(Tick 1)</i>	Yes <input type="checkbox"/>	<b>No – referred to wrong service for need</b> <input type="checkbox"/>	No – referred to wrong borough or client moved out of area <input type="checkbox"/>	
9	Did the client have a structured treatment need?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
10	Did the client need recovery support?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
11	On release did the client have a licence condition to attend treatment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
12	Was the CRC/NPS involved in facilitating engagement?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
13	If yes, how was the CRC/NPS involved?				
14	If an opiate user, was the client abstinent or on OST at the point of referral?	Abstinent <input type="checkbox"/>	<b>On OST - maintenance</b> <input type="checkbox"/>	On OST - reduction <input type="checkbox"/>	Don't know <input type="checkbox"/>
15	Was a Mental Health need flagged as part of the referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
16	Was a Housing need flagged as part of the referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
17	Was the client registered with a GP?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
18	If the referral was appropriate, was an appointment made with the client?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

19	Did the client attend the appointment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20	Date of appointment (DD/MM/YYYY)	____ / ____ / ____	
21	If the client did not attend the appointment, what was the reason (if known)?		
22	If the client did not attend the appointment was this followed up?	Yes – phone call/text <input type="checkbox"/>	Yes - letter <input type="checkbox"/> No <input type="checkbox"/>
23	If yes in Q.22, how many attempts were made to follow-up the client?	1 <input type="checkbox"/>	2 <input type="checkbox"/> 3 or more <input type="checkbox"/>
24	If the client did attend, was the client met at the gate on release?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25	Was the client already in treatment with the provider (prison short stay)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26	Triage Date (if a new episode) (DD/MM/YYYY)	____ / ____ / ____	
27	Intervention Start Date ( <i>first intervention following release</i> ) (DD/MM/YYYY)	____ / ____ / ____	
28	What intervention(s) were started? ( <i>Tick all applicable</i> )	Pharmacological <input type="checkbox"/>	Structured Psychosocial <input type="checkbox"/> Recovery Support <input type="checkbox"/>
29	Were the dates in Q.26 & Q.27 and intervention(s) in Q.28 recorded for NDTMS?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

## Appendix B: Prison NDTMS data items

The Prison NDTMS data items extracted for the audits were:

1. First name
2. Surname
3. Date of Birth
4. Sex
5. Client Reference (PNOMS ID)
6. Drug 1
7. Drug 2
8. Drug 3
9. Initial Reception Date
10. Prison Exit Date
11. Prison Exit Reason
12. Prison Exit Destination (DAT Code)
13. Referral on release status
14. Discharge Reason

These fields were populated for each client recorded as transferred to community treatment services.